California Health Policy and Data Advisory Commission
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Minutes
California Health Policy and Data Advisory Commission
October 17, 2003

The meeting was called to order at 10:12 a.m. by Chairman William S. Weil at the Hyatt Regency Hotel in Sacramento, California.

Commissioners

Present:
William S. Weil, MD, Chairperson
M. Bishop Bastien
Janet Greenfield, RN
Howard L. Harris, PhD
Paula Hertel, MSW
A. Peter Kezirian, Jr., Esq.
Thomas McCaffery, MPA
Hugo Morris
Kenneth M. Tiratira, MPA

Absent:
Marjorie Fine, MD
Jerry Royer, MD, MBA
Corinne Sanchez, Esq., Vice Chairperson

Staff Present:

CHPDAC: Jacquelyn Paige, Executive Director; and Raquel Lothridge, Executive Assistant

OSHPD: David Carlisle, MD, PhD, Director; Dale Flournoy, Interim Acting Chief Deputy Director; Deborah Ryan, Associate Director; Michael Kassis, Deputy Director, Healthcare Information Division; Scott Christman, Healthcare Information Division; Joseph Parker, PhD, Acting Deputy Director, Healthcare Quality and Analysis Division; Diane Dargan, Manager, Healthcare Information Resource Center; and MikeTagupa, Healthcare Information Resource Center

Also in Attendance: Dorel Harms, California Healthcare Association

Chairman's Report: Dr. Weil reported that the Commission has had a reduction in budget of approximately $25,000. To reduce staff travel costs, the October and December meetings are being held in Sacramento.

Transition usually does not greatly affect the Commission, due to the bipartisan composition of its membership, representing the people, and the many areas of healthcare. The Commission as a single body has always tried to be fair and equitable in its actions and in the best interest of the California population.

Approval of Minutes: The minutes of the August 5, 2003 meeting were approved.

OSHPD Director's Report – David Carlisle, MD, PhD, Director

Senate Bill 2, has been signed into law, creating a pay-or-play health insurance environment for California employer-based healthcare. The bill has received support from the healthcare spectrum and could significantly alter the presence of uninsured individuals in California. Implementation will be a phased-in process, with the first phase implementation date for employers in 2006.

The Health and Human Services Agency has conveyed that the current Administration and Governor-Elect Schwarzenegger are working together to promote a smooth transition. The department directors have been requested to ensure that this occurs. Directors have been asked not to submit resignations and instead to aid the transition as fully as possible. OSHPD employees have been asked to maintain the equilibrium to move forward effectively and efficiently in delivering services expected.

The Department of Finance has recognized the role, importance and distinction of special fund-supported departments versus largely General Fund-supported departments. For example, hospitals, through a fee assessment, pay for plan review and expect OSHPD to be efficient in delivering plan reviews. In discussions with Department of Finance and the Administration, it has been recognized that this function needs to be maintained and improved during this difficult time for California. Special fund-supported departments can actually contribute to the economic expansion through employment and construction, and can help reduce the budget deficit. Dorel Harms said that the California Healthcare Association is pleased that the additional staff will be approved for the building review process.

Medical Service Study Area Reconfiguration -- Scott Cristman, GIS Coordinator for OSHPD,

The medical service study area (MSSA) reconfiguration has been accomplished under the authority of the Healthcare Work Force Community Development Division, and under the larger umbrella of the enterprise GIS project. GIS stands for Geographic Information System, an integration of database technology and graphic display of a map. OSHPD is interested in GIS for access issues in healthcare. GIS allows the integration of the data sets to open up areas of analysis. These disparate data sets, which usually are not looked at together, can be layered so that relationships can be seen.

This is also a good tool for data management to organize information into an attribute data set, with a geographic display, for additional data analysis capabilities. A vision of OSHPD is equitable healthcare accessibility for California. Accessibility could mean physical

barriers to a facility or socioeconomic barriers. GIS can enhance the ability to assess these accessibility issues in the healthcare environment.

OSHPD's GIS feasibility study was the first one approved by control agencies in California. All the programs and divisions within OSHPD will be looked at in an attempt to leverage the information through GIS. Extensive work has been done using GIS in the natural resources and environmental planning areas. OSHPD is in the forefront for business applications for healthcare of this sort of technology being implemented. This activity will be a three-year phased approach. Staff is in the middle of a development cycle for the first web-based application to integrate several facility-based data sets (licensing facility information, patient discharge summary reports by hospital, and quarterly financial information) through one interface to meet the goal of equitable healthcare accessibility for California.

OSHPD collects patient discharge, utilization, and financial information, as well as construction and seismic safety information, all based on facilities as the common denominator. These data sets cannot always be shared. It was felt that geographic location of the facility is the common link. When this information is captured in a geographic framework, it can be retrieved through a single interface, and special analyses can be accomplished.

The MSSA automation project is based on geography and census tracks. A grant from the Health Resources and Administration provided additional resources for database development for the MSSAs, under the umbrella of the enterprise GIS. The MSSAs date back to the 1970s. County boundaries created problems because they are not representative of the populations within them, they are large, and have disparities of demographics, as well as urban and rural issues. At the federal level, metropolitan areas were defined by counties. In 1976, legislation created the Song-Brown Act to establish sub-county units to identify needs, specifically healthcare resource needs, based on census geography. General rules were set up to define inadequate healthcare resources within those areas, specifically primary care physician and other healthcare provider shortages. Later, there was a delineation of urban and rural areas. The ratio of physician to population was looked at, based on sub-county units. The criteria for a shortage area are now being reevaluated. Using 1990 census data, California moved to a census track based configuration.

Following 2000, census data were released necessary to redraw the areas. GIS and Healthcare Work Force and Community Development Division staff teamed up to redraw these areas. General guidelines of the MSSAs, as well as additional information important to the federal criteria such as poverty level, age 65-plus population were packaged into a GIS application. Staff participated in public meetings to obtain input from local providers, clinic directors, hospital administrators, county health officers, and others to determine the areas of need. Consensus was reached and there was public satisfaction. The results of the meeting were uploaded into the larger statewide repository. In 1992, there was federal recognition of the MSSAs, with accompanying federal monies.

There were 7,049 census tracks in California. There are now 541 medical service study areas based on good guidelines on population ranges, reflecting local input. Local participants were provided with information such as hospitals and clinics, physical features

like highways and local streets, cities, incorporated cities, and other communities that the census bureau recognizes, race and ethnicity. These MSSAs determine the amount of federal funds allocated for the areas.

Staff looked at criteria for areas of unmet need and purchased physician data to query primary care physicians in California. It was determined that there is one physician to 1,855 or more persons.

Update on Healthcare Quality and Analysis Division -- Joseph Parker, PhD, Acting Deputy Director, Healthcare Quality and Analysis Division

The reports on the CABG Reporting Programs and the progress report on the validation study for ICU outcomes were pended until the December meeting when Committee Chairman Jerry Royer will be in attendance.

The voluntary CABG report, using data for years 1997 through 1999, has been distributed. The Technical Advisory Committee has criticized OSHPD's timeliness of data reporting. There are several reasons for the lateness of data. The CABG project has been a voluntary program. Obtaining data from hospitals and making corrections is a lengthy process. The CABG program is based on clinical data collection and not based on the administrative data that OSHPD collects. During the last two years, OSHPD's responsibility has been to implement the mandatory California CABG Outcomes Reporting Program. Very few staff sources have been dedicated to the voluntary program. The division has been without a program manager for several months, and has had staffing problems due to the hiring freeze. Four full-time positions were going to be added to the program, but due to the freeze and other resignations, the division is down about five positions.

The report analysis shows that for years 1997-99, there were six hospitals that performed worse than expected and five hospitals performed better than expected. In the previous report released two years ago, it was found there was a significant relationship between risk-adjusted mortality outcomes and hospital volumes. This is pretty much in line with what has been found in the literature for the last ten years in terms of the volume outcome relationship between heart bypass surgery and mortality.

Two years are remaining in the voluntary program, using data years 2000 through 2002. Resources are scarce to go forward with the report for those years. The Office hopes to find a contracting alternative to produce that report. It is a goal that another voluntary report can be released before the mandatory hospital level report due date of 2005. A physician level report is due in 2006.

Participation by voluntary hospitals for the years 2000-01 is about the same as the current report, 71 hospitals. In 2002, due to the mandatory program, there has been a drop off in hospital participation in the voluntary program, with about 50 hospitals participating. The Hospital Association of Southern California has reviewed the report and is developing criteria to be used to evaluate outcome reports for the entire state.

The first mandatory program report, which is a six-month data window, was due to OSHPD on September 29 from the 120 hospitals that perform bypass surgery in California. About

12 hospitals requested extensions. To date, all but five have been received, which is still within their extension deadlines.

The mandatory program has been receiving much cooperation from hospitals. Physicians are somewhat concerned, but they have been assured they will have multiple opportunities to look at their data and make corrections before the reports are released.

The community acquired pneumonia report was distributed to hospitals for a 60-day review period about two weeks ago. This is a new report for years 1999 through 2001, and incorporates do-not-resuscitate (DNR) and condition present at admission (CPA) codes that are used in the patient discharge data. The condition present at admission code is used to distinguish conditions that might be present at admission from complications that might occur as a result of medical care. Perhaps only one other state currently uses the CPA code. The CPA code has now been adopted as one of the national standards. The final report will contain comments from hospitals and will be published in early 2004. Since this is a new report, the report will require approval by the Health and Human Services Agency and maybe the Governor's Office.

The timeliness issue should improve with the mandatory program if additional staff can be hired. A different kind of report (benchmark report) can be produced, where the data will not undergo as much scrutiny as has been done in the past. There is always a trade off between timeliness and the quality of the data. Staff is exploring the use of patient discharge data, which is now being reported more timely, to do the benchmark reports using risk-adjusted mortality and AHRQ indicators that have been identified for healthcare research and quality. Initially, staff is beginning to look at stroke and perhaps Triple A repair.

A press release to all California newspapers announced that the CABG report is available, and the report has been placed on the website. The report has been sent to hospitals, healthcare organizations, government, and other interested organizations. The Pacific Business Group on Health collaborated with OSHPD in this report, and has placed the report on its website in a more user-friendly fashion. Many health plans are using the information in their tiered pricing structure.

Commissioner Morris urged that employers and unions be informed about the coincidence of volume, mortality and cost, and will personally help Dr. Parker identify these organizations.

Healthcare Information Resource Center – Diane Dargan, Manager

A new brochure describing the activities of OSHPD was distributed. The brochure was developed with input from all the divisions.
Pivot tables, which are data in Excel spreadsheets, allow the selection of certain criteria. Pivot tables for financial data are available for fiscal years 2000 and 2001.

The second quarter of 2003 quarterly data is now available electronically. As soon as the data are submitted, the data are available for public use.

The utilization database collected once a year is in development now, which is the ALIRTS system. Some of the reports are already available on that system, which is similar to the quarterly data where the facilities submit their data electronically and reports are available as soon as they are submitted. Long-term care financial disclosure data are available for fiscal years 2000 and 2001. Primary clinic utilization data for 2002 are available, and specialty clinic data are available for 2001. The timeline for all the utilization data to be available is February or March 2004, and will be available as soon as it is submitted. Home health agency and hospice utilization data will be submitted through ALIRTS.

Discharge data for 2002 are available as a result of MIRCal. Data for the entire year 2003 will be available within a couple of months. Using contractors, linking of the research data sets has been completed. Discharge data are linked every year with vital statistics, birth and infant death files, and vital statistics death files. Staff worked with Department of Health Services staff to link the Medi-Cal data with the discharge data. OSHPD provides researchers with a non-identifiable file for the link to Medi-Cal data and DHS has the identifiable file.

Staff is in the process of redesigning the website to make it more user friendly and compliant with the American Disabilities Act. When graphics are used, a table behind it is necessary for the visually impaired. If they have readers, they can follow the data in the table. This should be completed in January.

The county perspectives publications containing 2000 data, combines information from all the databases, as well as population and economic data, and will be available on the web within a month.

A pivot table is being developed for 16 ambulatory care sensitive conditions. Particular conditions can be selected for counties and regions by race and ethnicity.

Staff has been working to develop products using GIS. A patient origin map is being developed where one can select a facility and see on a map where the patients are coming from and by density. This is being done in-house, and expected to be on the website within the next year.

HIRC has disseminated over 3,000 products to requesters in the past year, and handled almost 8,000 information requests by phone, e-mail and walk-ins. Staff has referred 554 persons to the website (OSHPD@STATE.CA.GOV). In the past three years, the website use has increased by 300 percent. Besides the United States, 35 countries have accessed the web, with about 4,000 visits from these countries in the past nine months, when the information began to be collected.

In response to which countries are accessing the site, it was answered that Canada, Japan, Australia, all of the European countries, and all of the Asian counties are accessing the site. Germany and Japan are the heaviest users of the countries. Dr. Carlisle mentioned that some academicians, primarily from Japan, recently visited and were interested in how OSHPD makes information available about healthcare utilization, especially in the HIPAA era.

Patient Origin and Market Share Pivot Table – Mike Tagupa

The pivot table is an Excel function that allows users to look at large amounts of data and do some querying in an easy fashion. The patient origin and market share pivot tables were created in response to a need for users to do some patient origin studies, to look at a particular facility and find out where patients are coming from. With the changes in masking of the discharge data, this was more difficult to do. The pivot tables do not need the full data set. This information is available on the Internet. The file is large so it works better on a high speed Internet. The website is under development and will not be available for probably another year, using the enterprise GIS.

One of the base layers of GIS is the political districts. Discharge data cannot be mapped, but can be matched to zip codes. Discharges do not contain street addresses and cannot be plugged into the MSSAs, which are census tracks. However, the zip code location of the patient and the location of the hospital can be indicators. The query could be cut by specific age groups or look at specific payers such as Medicare, Medi-Cal, private coverage, self-pay, etc. Some of the demographics are masked out for the public data set before privacy and confidentiality begin to surface. There is a lot of aggregation done before it gets to this point, such as broad age ranges. The unmasked data are available only to researchers. The market share pivot table uses zip codes and can look at specific DRGs, age groups and pairs.

Some concerns expressed by consulting firms are that OSHPD is cutting into their business. OSHPD has put tools into the hands of individuals. The firms have taken it to the next level and are able to do more sophisticated analyses for their clients. This is not putting anybody out of business, but advancing the quality of analysis.

Legislative Update -- Deb Ryan, Assistant Director

Three health professions education bills have been chaptered, and are similar in format and purpose to current legislation for registered nurses.

(see attached list of legislation that passed and was signed by Governor in 2003)

SB 2 (Speier/Burton) was signed into law and is the pay-or-play approach to expanding access to healthcare coverage. This approach has already been implemented in Hawaii, where about 94 percent of the population there is covered. Jack Lewin, Executive Vice President of the California Medical Association, was the commissioner of health responsible for implementing this in Hawaii.

Commissioner Morris suggested inviting Dr. Lewin and Assemblyman Keith Richman, who has had some legislative activity in the healthcare field, to make a presentation at a future Commission meeting.

Healthcare Information Division Update -- Mike Kassis, Deputy Director

The MIRCal regulations have been approved and adopted. There was concern expressed at prior meetings of the Commission and its Health Data and Public Information Committee about allowing enough extension days to facilities for filing their reports.

Previously, while many hospitals submitted reports on time, no report was ever approved as of the first submission of data. The report was open for editing for a six-month period after the deadline. All facilities used extension dates. The majority of facilities used 21 or more extension days. Report period data were available anywhere from 12 to 18 months after the close of the report period.

With MIRCal, for the last half of 2002, the report period opened for editing 15 days after the close date; 75 percent were approved by the report period due date. The due date is now three months after the close of the reporting period. About 25 percent of the facilities used extension days; less than half used more than seven days. The report is now available five months after the close of the report period, instead of 12 to 18 months.

Beginning with 2004 data, extension days will drop from 45 to 28 days. In 2005, the extension days will drop to 14. If there are extenuating circumstances, facilities are not penalized for late submission. The next goal will be to shorten extension days and the report due date from 90 days down to 45 days.

Emergency room and ambulatory surgery data collection will begin in late 2004, and the 45-day window will be used. If experience shows this is not feasible, OSHPD has administrative authority to push it up. The goal is to receive the data accurately, efficiently, and make it available quickly.

Automation of the annual utilization reports from clinics was done a couple of years ago. The clinics are very pleased with the process. Automation of hospitals and nursing homes, home health agencies and specialty clinics is in progress. It is the first time they have used the online system, with edits, to report utilization data. Once the report is submitted and fatal errors have been corrected, the data goes into the database and immediately becomes available. The website is: HTTP://alirts.oshpd.ca.gov. The www does not work. Facilities need a web browser and a good Internet connection. Annual utilization reports include hospitals, nursing homes, clinics, specialty clinics, home health agencies, hospices, skilled nursing and intermediate care.

OSHPD has had two information technology projects in the past three years, MIRCal and ALIRTS, both success stories.

Future Meeting Dates:

February 10, 2004	South (Burbank area preferred)
April 20, 2004	North
June 15, 2004	South
August 20, 2004	North
October 19, 2004	South

The next meeting will be held on December 8, 2003 in Sacramento. The annual dinner will be held at Frank Fats on Sunday, December 7, 2003. Commissioners, former commissioners, and guests are invited.

Adjournment: The meeting adjourned at 2:04 p.m.